

Bureau of Health Care Quality and Compliance

3/29/10 POC accepted
B. Casanovi HFSM

PRINTED: 03/03/2010
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS263S	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2010
NAME OF PROVIDER OR SUPPLIER HENDERSON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1180 E. LAKE MEAD DRIVE HENDERSON, NV 89015 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Z 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 02/12/10, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing. Complaint #NV00023833 was unsubstantiated with no deficiencies cited. Complaint #NV00024399 was substantiated with a deficiency cited. (See Tag Z230). A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	Z 000	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Henderson Healthcare Center agrees with the allegations and citations listed on the statement of deficiencies. Henderson Healthcare Center maintains that the alleged deficiencies do not, collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Henderson Healthcare Center's written credible allegation of compliance. By submitting this plan of correction, Henderson Healthcare Center does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Henderson Healthcare Center reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.		
Z230 SS=D	NAC 449.74469 Standards of Care A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the patient's highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care developed pursuant to NAC 449.74439.	Z230	Z230 Severity: 2 Scope 1		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6889

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If continuation sheet 1 of 2

Bureau of Health Care Quality and Compliance

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Z230	Continued From page 1 This Regulation is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide restorative nursing services following discharge from physical therapy to maintain the highest practicable physical well-being for 1 of 2 residents (Resident #2). Severity: 2 Scope: 1	Z230	<p>a. Resident #2 was re-evaluated for restorative program. Restorative services for this resident implemented on 3/9/2010.</p> <p>b. A 100% audit of all residents discharged from therapy since the last day of survey was conducted. No other residents were noted to be affected. Random audits will be conducted utilizing the RA audit tool to assure others are not affected.</p> <p>c. Evaluations for restorative will be completed upon discharge from therapy. Orders will be written per attending physician for type, length of time and restorative program to be implemented. Monthly evaluations of progress will continue in the restorative program.</p>		

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STATE FORM

6899

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If continuation sheet 2 of 2

- d. Review of audits will be conducted monthly at facility quality of care meetings. Results will be tracked and trended for review at performance improvement meetings.
- e. Individuals responsible for compliance will be Resident Care Managers, Restorative Nurse and Director of Nursing.
- f. Compliance date is 3/12/10.